CHAPTER 8

FINDINGS AND SUGGESTIONS

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FINDINGS AND SUGGESTIONS

8.1 Introduction

This chapter illustrates the summary, findings, suggestions and conclusion of the study. The first part provides a brief account of the method used for the study. The second part describes the major findings of the study. The third part discusses suggestions based on the findings of the study in four areas viz. recommendations for government/policy makers, recommendations for the rehabilitation centers, recommendations for future research and recommendations for the social work profession. And, the last part concludes the study.

Section 1: Summary

This study explored the rehabilitation facilities and rehabilitation outcomes of homeless mentally ill in Kerala. The study tried to answer seven research questions. What are the rehabilitation processes used by these care facilities? What are the facilities provided at each center?, What is the quality of patient care services?, What are the personal profile of the chief functionary of the rehabilitation centers and their motivations for setting up and maintaining such facilities?, What is the level of knowledge and attitudes of care providers on mental illness?, What is the level of satisfaction of the residents?, How much is the quality of life and level of functioning of the homeless mentally ill?.

The objectives and hypotheses of the study were:
8.2 Objectives

General Objective

To study the facilities for care and psychosocial rehabilitation and rehabilitation outcomes of homeless mentally ill in Kerala.

Specific Objectives

1. To study the facilities for rehabilitation in the rehabilitation centers for homeless mentally ill in Kerala.
2. To examine the methods adopted for care in the rehabilitation centers.
3. To assess the quality of patient care services offered by the rehabilitation centers.
4. To explore the personal profile of the care providers of homeless mentally ill.
5. To study the knowledge and attitude of the care providers regarding mental illness.
6. To assess the level of functioning of mentally ill residing in the care centers.
7. To assess satisfaction of residents in the care facilities.
8. To explore the quality of life of residents in the care facilities.

8.3 Hypotheses

1. The quality of life of homeless mentally ill increases with higher level of functioning
2. Better the quality of patient care services better would be the level of functioning of the mentally ill receiving care

3. Better quality of patient care services better would be the quality of life of the mentally ill receiving care

4. Better the orientation to mental illness of the care providers higher will be the quality of life of mentally ill

5. Better the orientation to mental illness of the care providers higher will be the level of functioning of mentally ill

8.4 Method

The study collected data from three data sources viz. 1. Chief functionary of Rehabilitation facilities: The researcher interviewed the chief functionary of 20 rehabilitation facilities selected for the study, with an aim of studying the functioning, facilities and services of the centers, 2. Persons with mental illness residing in the rehabilitation centers: The researcher interviewed 181 respondents from the selected centers for assessing the rehabilitation outcomes and patient satisfaction, 3. Volunteer care providers: All the volunteers working in the centers were interviewed for assessing the orientation to mental illness among the care providers. Researcher collected data from 66 care providers.

The study used a combination of Explanatory and Quasi experimental – After only design (Post test only) evaluation design. The explanatory study tries to establish cause effect relationship and describe phenomena.
In the evaluation design, the study performed both process and outcome evaluation.

The study used interview schedules for the study of rehabilitation processes and profile of chief functionary and care providers. Basic socio-demographic data and satisfaction of the residents were collected using an interview schedule. WHO QoL scale was used to measure the quality of life and level of functioning scale and Global Assessment of Functioning Scale for measuring the functioning. The care providers’ orientation to mental illness was assessed using orientation to mental illness scale.

Section 2: Major Findings of the Study

The following section portrays the salient findings of the study.

8.5 Profile of the Rehabilitation Facilities

8.5.1 General Information

This section portrays findings of the study related to general information related to the rehabilitation centers.

1. All the rehabilitation centers were registered. 70 percent of the centers were registered as trust and 30 percent as society.

2. All the centers had completed a minimum of 5 year of service. The mean years of existence of the rehabilitation centers are 11.1 years with a standard deviation of 3.16 years. The first organisation was established in 1991 and has 18 years experience in rehabilitation.
3. 95 percent centers had public donation as their main source of income. None of the institutions charged any fee for their services, 65 percent relied on agricultural and other products as their source of income.

4. Among the centers 5 percent were registered under Foreign Contribution Regulation Act (FCRA) and the majority 95 percent were not registered under FCRA.

8.5.2. Facilities for Care and Rehabilitation

This section deals with various facilities available for care and rehabilitation of homeless mentally ill the rehabilitation centers.

5. 75 percent of the centers operated in the building owned by the organization.

6. The centers had an average of 8 rooms and 8 toilets.

7. The centers had an average number of 99 residents. The number of residents range from 12 to 260.

8. Number of resident to room ratio was 13 (One room for 13 persons) and resident to toilet ratio was 12 (one toilet per 12 persons).

9. 20 percent were satisfied Very Much with the space and 40 percent rated satisfaction To Great Extent and 15 percent had satisfactory level of satisfaction and 25 percent were Somewhat Satisfied with the space of their centers.
10. 70 percent of the centers owned vehicles, all had telephone facility, 55 percent of the centers had computers. 15 percent of centers had fax facility and 25 percent had audio visual aids.

11. All the centers functioned with the support of volunteers. 20 percent of the centers had a visiting psychiatrist, 20 percent of the centers had social workers and nurses in their staff. None of the rehabilitation centers received services of occupational therapist and psychologist.

12. The centers had an average of 5 staff for the activities. The number of staffs ranged between 1 and 17. An average of 10 recovered patients was actively involved in the day to day activities.

13. 10 percent of the centers were Very Much Satisfied with the staffing pattern of their center. 50 percent were satisfied To Great Extent, while 30 percent rated the staffing pattern to be Satisfactory. 5 percent of the centers were Somewhat Satisfied and the remaining 5 percent of the centers were Not At All satisfied with the staffing pattern.

14. 40 percent of the chief functionaries were satisfied with the knowledge of the staff on Mental Illness, 45 percent graded it to be of satisfactory level and 15 percent were Somewhat Satisfied with the knowledge level of staff on Mental illness.

15. 5 percent of the chief functionaries were Highly Satisfied with the skill level of their staff, 65 percent were satisfied To Great
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Extent, 15 percent graded the satisfaction level to be Satisfactory and 15 percent graded the satisfaction level to be Somewhat Satisfactory.

16. 80 percent centers opined the need for staff training to be Very Much.

17. 65 percent required no additional staff, 25 percent of the centers would like to have Psychiatric social Workers to be included in the team while 10 percent of the centers requires Nurses in their team.

18. All the centers had admissions due to homelessness. 40 percent admissions were due to poor social network, 20 percent admissions were due to neglect of the Family.

19. 85 percent of the centers admit homeless mentally ill. 85 percent of the centers admitted patients brought by public. 80 percent of them had admissions of patients brought by police. 65 percent of the centers took admissions of patients brought by family. 25 percent of the centers had residents referred by Health/Mental Professionals.

20. 40 percent of the centers studied served only men and 25 percent centers were exclusively for women and 35 percent served both men and women.

21. The rehabilitation centers catered to an average of 99 clients in total and 63 males and 36 females. Out of 99 clients an average of 91 was severely mentally ill.
22. All the Rehabilitation centers worked as long stay homes, none were providing outpatient services, day care services and night hostel, while 10 percent of the centers functioned as sheltered workshops, 5 percent of the centers functions as half way homes, and 5 percent of the centers provided emergency services.

23. 20 percent of the centers had Psychiatrist visit their centers while the majority 80 percent took the residents to the Psychiatrist whenever required.

8.5.3 Methods Adopted for Care in the of the Mentally Ill

The methods adopted for the care and rehabilitation in the rehabilitation centers are outlined here.

24. 95 percent of the centers involved the residents in routine activities, 65 percent involve the residents in vocational activities, 15 percent of the centers were providing social skill training and none were practicing Rehabilitation assessment, rehabilitation Planning or the Behaviour modification techniques with their residents.

25. 65 percent centers had structured schedule for selected residents, 25 percent had structured schedule for all residents and structured schedule was absent in 10 percent of the centers.

26. 55 percent of the centers were able to involve all the capable residents in rehabilitation activities and 45 percent were not able to involve all the capable members of their center into various rehabilitation activities.
27. 25 percent of the centers were not able to engage in rehabilitation activities as staffs were not adequate, while 40 percent due to lack of trained personnel, 10 percent due to poor skills of available personnel, 20 percent due to lack of infrastructural facility and 5 percent due to problems in marketing of the products made.

28. Majority of the centers used natural vocational activities like dairy (65%), agriculture (55%), horticulture (45%), and poultry (40%). The study further showed that 5 percent of the centers engaged the residents in cover making, 15 percent in tailoring, 10 percent in printing, and 5 percent in craft. 10 percent of the centers involved the residents in vocational activities like cultural, piggery etc.

29. None of the centers gave any monetary incentives for the vocational activities.

30. Major leisure time activity offered in the centers was television (100%), followed by music (40%), outdoor games (35%). 10 percent of the centers engaged their residents in indoor games, 5 percent of the centers promoted dance and 5 percent entertained them with radio.

31. The average monthly cost of care for the homeless residents was 985 rupees.
32. 15 percent of the centers rated their attempts to discharge the residents as *most often*, 50 percent as *often*, 25 percent as *sometimes* and 10 percent as *rarely*.

33. The reasons for not able to discharge the residents were lack of address (95%) and no family to return (95%). 85% of the centers had difficulty in discharging due to the unwillingness of family to take the resident back. 15 percent of the institutes faced the problem of unwillingness of the resident to go back to his home. 10 percent faced the problem in discharge due to poor outcome of treatment.

34. Networking with other organizations (60%) was found to be the major method for discharge. The centers also adopted home visits (45%) and family psycho-education (30%) for the reintegration of the residents to families.

35. 90 percent of the centers maintained separate case file for their residents while 10 percent of the centers had no such practice.

36. The centers rated support obtained from the community as very good (25 percent), good (65 percent).

37. 25 percent of the centers attempted to educate the Public regarding Mental Illness while the majority 75 percent of the centers were not into it.

38. 35 percent of the centers expected financial support and infrastructural Support, 15 percent needed more staff, while 15 percent of the centers did not expect any support.
8.6. Quality of Services Provided by the Centers

This section provides details of the quality analysis of the centers on five dimensions. The dimensions assessed were cleanliness, quality of recording, accommodation, dressing and food. The quality was analysed using a 5 point Lickert scale rated as Very Good to Very Poor.

39. **Cleanliness:** 45 percent had poorly maintained premises and facilities, 40 percent had satisfactory cleanliness, 5 percent each were rated very good, good and very poor.

40. **Recording:** 40 percent of the centers had satisfactory recording processes, 35 percent had poor recording processes, 15 percent had good recording and 5 percent of the centers each had very good and very poor recording system.

41. **Quality of accommodation:** 10 percent were rated as Very Good, 50 percent as Good, 25 percent as Satisfactory, and 15 percent as Poor.

42. **Quality of dressing:** In the dressing dimension 10 percent received Very Good, 75 percent Good and 5 percent Satisfactory and the balance 10 percent Poor rating.

43. **Quality of food:** 10 percent were rated very good, 75 percent as good, 10 percent as satisfactory and balance 5 percent as poor.

44. **Quality of patient care services:** Quality of patient care services was rated based on seven parameters identified viz. 1)
Rehabilitation processes, 2) Availability of structured schedule for residents, 3) Percentage of residents involved in productive activities, 4) Ratio of number of severely mentally ill to number used in rehab activities, 5) Ratio of Number of Residents to number of rooms, 6) Ratio of number of residents to number of toilets, and 7) Ratio of number of residents to number of staff (volunteer staff plus recovered patients used as staff). Considering the seven parameters 20 percent of the centers displayed Very Good overall quality of patient care services, 20 percent were Good, 25 percent were Moderate, 10 percent were Satisfactory, 20 percent were Poor and 5 percent were Very Poor.

8.7. Profile of the Chief Functionary

A personal profile of the chief functionary of the rehabilitation centers are given below.

45. 80 percent of the chief functionaries were men and the remaining 20 percent were women.

46. The chief functionaries of the rehabilitation centers had a mean age of 51.9 with a standard deviation of 12.24. The age ranges from 35 to 71.

47. They had 11.2 mean years of education. The highest number of years completed education is 18 years. The range was 16 years.

48. 70 percent of the chief functionaries were married. Out of the remaining 30 percent 15 percent were Nuns, 5 percent were
priests and single and widower status constituted another 5 percent.

49. The religious status of the chief functionaries showed that all the care givers were Christians.

50. 35 percent adopted the profile of caring homeless mentally ill from their personal experiences, 45 percent had the inspiration from Religious Beliefs, 10 percent of the respondents were motivated by others and the remaining 10 percent were being assigned by the organization to take care of the mentally ill.

51. 60 percent of the chief functionaries were residing in the center.

52. 35 percent of the chief functionaries spent more than 12 hrs in the center. 35 percent spent almost 8 to 12 hrs in the center, and 25 percent spent 4 to 7 hrs.

53. Only 40 percent of the chief functionaries had training on psychosocial rehabilitation.

54. 55 percent of the chief functionaries perceived satisfactory knowledge on mental illness, and psychosocial rehabilitation. 55 percent were very much satisfied with their skills in dealing with mentally ill.

55. The study of impact on the personal lives of the chief functionaries revealed that majority of the chief functionaries had impact Rarely or Never on the personal life in all the
domains included viz. family life (80 percent), Family Finance (90 percent), family Leisure (90 percent), time with family (90 percent), family celebration (90 percent), Education of Children (100 percent), health of family members (95 percent) and prestige of family (90 percent).

8.8. Profile of Care providers (staff)

Findings related to the profile of the care providers working in the rehabilitation centers are given below.

56. 62.1 percent of the care providers were men and 37.9 were women.

57. 47 percent and 45.5 percent of the care providers were single and married respectively. 7.6 percent of them were divorced.

58. The mean age of the care providers were 37.79 ± 7.64 (Mean ± SD)

59. The care providers have completed 9.21 years of education

60. The care providers have mean experience of 4.38 years

61. Majority of the care providers (71.2 percent) provided their services free of charges and only 28.8 percent were paid for their work.

62. Religious beliefs motivated 68.2 percent of the care providers to choose this work and 24.2 percent were motivated by personal life experiences. 7.6 percent of them were motivated by others to perform the role.
63. Majority of the care providers (65.2 percent) haven’t received any scientific training on psychiatric disorders. 34.8 percent received training on psychiatric disorders.

64. 47 percent of the care providers expressed confidence to Great extent. 30.3 percent had no opinion and 22.7 had confidence to a great extent in the care of the mentally ill.

65. In the knowledge domain 51.5 percent perceived of having knowledge to great extent, 28.8 percent satisfactory and 19.7 percent somewhat satisfactory.

66. 45.5 percent opined that they had skills to deal with mentally ill to great extent while 33.3 percent had satisfactory and 21.2 percent somewhat satisfactory skills.

8.9. Care Providers’ Orientation to Mental Illness

The care providers knowledge and attitude towards mental illness was assessed using the orientation to mental illness scale. Findings in terms of mean scores and standard deviations of the subscales of the scale are displayed below. The meaning of the scores is discussed in the subsequent lines in each finding.

67. The mean score of folk belief is 2.10±0.30, psychosocial stress is 2.79 ± 0.32, organic causation is 2.59±0.39 and causation total is 2.48± 0.29. The mean scores indicated that the care providers have favorable orientation to mental illness in all the subscales of the domain of causation.
68. The mean score of non restrained behaviour is 1.62±0.35, weak cognitive control was 2.44 ± 0.44, fidgety behaviour is 2.05±0.52, bizarre behaviour is 2.35±0.44 and perception of abnormality total is 2.01± 0.32. The mean score of the subscale non restrained behaviour shows a *Highly Favorable* orientation towards mental illness among the care providers. The mean scores of other subscales indicate that the care providers have *Favorable* orientation to mental illness. The mean score of the perception of abnormality total indicate a favorable orientation (2.01) closer to a highly favorable orientation.

69. The mean score of physical methods 1.42 ± 0.50 indicated a *Highly Favorable* orientation to mental illness in that subscale. The mean scores of 2.52 ± 0.33 and 2.52 ± 0.43 in the folk therapy and psychosocial manipulation respectively, indicate *Favourable* orientation in the subscales. The mean of treatment total (2.29± 0.24) also reveals *Favourable* orientation.

70. The subscales hopelessness, hypo-functioning, and rejection of mentally ill yielded mean scores of 2.33 ± 0.34, 2.22 ± 0.36, 2.08 ± 0.37 respectively. The score indicated that the care providers have *Favourable* orientation in all the subscales of aftercare. The total score of the domain aftercare also had a *Favourable* orientation to mental illness.
8.10. Profile of the Residents

Findings of the data collected from the residents of the rehabilitation centers are given below.

71. Majority of the respondents were men (61.9 percent) and 38.1 percent were women.

72. The mean age of the residents selected for the study was 38.62 years. The age range was 41 with maximum age 63 years and minimum age 22 years.

73. The residents had an average duration of 3.83 years stay in the centre. The range of stay is 11 years. The respondents included persons stayed for 1-12 years.

74. 50.8% of the respondents were single, 24.9 percent were married and 13.3 percent were divorced, and 11 percent of the residents were separated.

75. The residents selected for the study were a heterogeneous group consisted of 45.9 percent Christians, 32 percent Hindus and 22.1 percent Muslims.

76. Majority of the residents (54.2 percent) lived in streets prior to admissions to the rehabilitation center. 38.1 percent of the residents were marginally housed, and 7.7 percent lived in other rehabilitation centers.
8.11. Level of Satisfaction with the Center

The residents’ level of satisfaction to the physical facilities and rehabilitation activities are presented below.

77. Majority of the residents (68.5 percent) opined that the activities performed by them helped to reach the goal to some extent, while 13.8 percent felt that it helped to a great extent and 13.3 percent had no opinion and 4.4 percent believed that it never helped.

78. 54.1 percent of the commented that they have role in the treatment plan to some extent, while 28.2 percent believed that they have role to a great extent, 12.2 percent had no opinion and 5.5 percent felt that they had no role in the treatment plan.

79. 54.7 percent of the residents felt that they had a great improvement since the admission. 26 percent had improvement to some extent, 18.8 percent had no opinion on the improvement and 0.6 percent felt that he/she had no improvement at all.

80. Majority of the residents (63.5%) were satisfied with the overall functioning of the center, while 29.3 percent were neither satisfied nor dissatisfied with the overall functioning. While 6.6 percent were dissatisfied with the centers, 0.6 percent was highly satisfied.

81. With regard to facilities 53.6 percent, 8.3 percent and 1.7 percent of the residents were satisfied, dissatisfied and very
satisfied with the facilities respectively. 36.5 percent were neither satisfied nor dissatisfied with the facilities.

82. 70.2 percent of the residents were satisfied with the staff. 13.8 percent were neither satisfied nor dissatisfied, 8.3 percent were highly satisfied and 7.7 were dissatisfied with the staff.

8.12. Rehabilitation Outcomes

The findings of the rehabilitation outcomes of the residents are portrayed in this section. The rehabilitation outcomes were measured as quality of life and level of functioning of the residents.

8.12.1. Quality of Life

The scores obtained by the residents in the four dimensions the WHO quality of life scale is discussed below. The mean scores are given out of 100.

83. The domain 1 – physical health yielded a mean score of 54.5 indicated moderate level of quality of life in the area of physical health.

84. Mean score Psychological health domain was 47.3. The score indicated moderate levels of perceived psychological health among the homeless mentally ill.

85. Domain 3 related to social relationships had a mean score of 49.1. The score indicated that the residents perceived moderate level of social relationships.
86. The mean score of the domain 4 related to environment was 60.90. This score showed near to high level of quality of life in the domain of environment.

8.12.2 Level of Functioning

The findings of the level of functioning assessed in four dimensions are given below. The meaning of the mean scores presented is given in the subsequent lines of each finding.

87. The mean score of community living was 1.96. The score indicated that the residents had very low functioning in the area of community living.

88. The mean score of interpersonal relationship was 2.33. The score revealed that the residents had low levels of functioning in interpersonal relationship.

89. The mean scores of 3.18 in mood disturbance and 3.30 in psychotic symptoms showed that the residents had low level of functioning in the two domains.

90. Dangerous behaviour and physical functioning were found within normal limits as the means were 3.51 and 3.52 respectively.

8.13 Relationships between Variables: Testing of Hypotheses

This section displays inferences drawn from testing of hypotheses showing relationship between variables.

92. “The Quality of life of homeless mentally ill increased with higher level of functioning”.

93. The social relationship in the quality of life domain showed significant positive correlation to scores of functioning assessment in the areas of Interpersonal relationships (p<0.05), mood disturbance (p<0.05), psychotic symptoms (p<0.01), physical functioning (p<0.05), and functioning total (p<0.01). All the domains were positively correlated. The findings suggested that the social relationship of the residents improved greatly with reduction in mood disturbances and psychotic symptoms and improvement in physical functioning and overall functioning.

94. The total score of quality of life showed significant correlation with mood disturbance (p<0.05) and psychotic symptoms (p<0.05). This finding revealed that reduction in mood disturbance and psychotic symptoms have significant impact on the positive quality of life.

95. The Environment domain of quality of life showed significant relationship to mood disturbance (p<0.05) indicating that the quality of life in relation to environment is dependent on mood disturbance. The variables were positively correlated
suggesting that normal functioning of mood results into better quality of life in the Environment domain.

96. Better the quality of patient care services better would be the level of functioning of the mentally ill receiving care

97. Better quality of patient care services better would be the quality of life of the mentally ill receiving care

98. Orientation to mental illness of the care givers had no relationship to quality of life of the residents.

99. The psychological functioning (mood disturbance) was related to the care providers’ orientation to mental illness and sub-domains such as perception of abnormality, treatment and after care.

100. The orientation to mental illness was not related to other domains of level of functioning viz. community living, interpersonal relationship, psychological functioning (psychotic symptoms), psychological functioning (dangerous behaviour), and physical functioning.

101. Rating of skills in dealing with mentally ill had significant relationship to the functioning of the residents in the area of community living (p< 0.05) and physical functioning (p < 0.05)
Section 3: Suggestions

8.14. Policy Implications and Government level action

1. Considering the number of homeless persons rehabilitated by the rehabilitation centers, low cost care and positive outcomes displayed by the residents as proven in this study, these centers for rehabilitation are proven to be necessary for supplementing effort of Government in the care of severe and persistent mentally ill especially the homeless. The MHA, 1987 needs amendment to include realistic guidelines for establishment and maintenance of rehabilitation centers as it has talked about psychiatric hospitals and nursing homes. The policy makers also could think of an alternative legislation or amendments in existing ones viz. PWD Act, 1995; RCI Act, 1992.

2. The state mental health authority shall develop operational guidelines for the rehabilitation centers to ensure quality and uniformity in service delivery. This would facilitate development of realistic guidelines for training requirements of personnel, rehabilitation processes and documentation.

3. A committee consisting of mental health professionals and representatives of the rehabilitation centers could be constituted for developing the operational guidelines.

4. State mental health authority shall make periodic visits to these centers to ensure quality as suggested in the Mental Health
Chapter 8

Act, 1987 for private nursing homes (board of visitors, board of inspectors).

5. The board of inspectors to such centers shall include representatives of Kerala Federation of Care of Mentally Disabled (KFCMD) and trained psychiatric social workers.

6. The state mental health authority shall devise a training package for the caregivers in these centers.

7. A training manual could be prepared with the support of mental health professionals.

8. Government shall consider supporting the centers with grants under different schemes available with department of social welfare, education, health etc.

9. The vocational rehabilitation activities could be supported through schemes of Khadi and village Industries.

10. The permanent housing needs of the rehabilitated person could be linked to Ashraya scheme of Kudumbashree and other housing schemes for the poor.

11. Government shall consider funding for ‘community based supported group homes’ for recovered homeless persons and provide opportunities for the centers to act as Half Way Home.

12. The government, ICMR, WHO may support more research in this area and attempt to document best practices.
13. The District Mental health programmes shall perform their outreach in these centers and supply free medicines to the residents.

14. The Government shall consider devising pension, welfare schemes and funds for homeless mentally ill.

15. The local self governments shall allocate funds for these centers in their plan fund for differently abled.

8. 15. Recommendations for the Centers

16. The KFCMD and centers shall frame polices for quality assurance. They shall devise an operational guideline for the effective programme delivery. A manual for care giving could be prepared as a step by step guide in rehabilitation of the homeless mentally ill.

17. The center chief functionaries shall meet at least once in a quarter to review the functioning of the centers.

18. The volunteers/care providers shall be trained on basic concepts of mental disorders and psychosocial rehabilitation. The practical wisdom of the carers should be coupled with scientific knowledge. On the job, refresher training programmes may be organised.

19. The focus of care shall be recovery and short term treatment. The centers should promote community reintegration or transition to new ways of housing for the recovered residents.
20. The centers shall develop a local advisory committee with an aim of guiding the processes and ensuring sustainability and credibility of operations.

21. The linkages with Local Self Governments need to be enhanced. The centers shall consider ongoing support from the LSG for some specified activity in the center.

22. The centers shall engage each resident on a structured activity schedule based on their functional ability. This would support their personalized rehabilitation goals.

23. More recovered mentally ill should be utilized for routine functioning of the center.

24. Vocational activities need to be streamlined with regular evaluations of the outcomes obtained by residents.

25. The centers should focus on productive rehabilitation/vocational activities and may consider providing behavioural or monetary incentives for work performance.

26. The recovered and skilled persons may be trained in a specific vocational area and shall be made the supervisor for the vocational activity in the center itself.

27. The centers shall develop network with other organisations and shall create opportunities for transitional, supported and permanent employment opportunities for recovered persons.
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28. The centers shall use the community resources like self help groups, Local Self Government, other non-governmental organisations, community members, and government/private health care facilities, social welfare etc. for the benefit of the residents. This would help in reducing the burden of the care centers.

29. The centers shall extend their work to patients discharged from the hospitals and shall act as half way home for them as a step towards prevention of homelessness.

30. The quality of life of the residents is predicted by symptom reduction and level of functioning. Hence focus should be on symptom reduction and enhancing the level of functioning. A skills training package could be developed for preparing clients for higher levels of functioning.

31. The functional status of the patients could be analysed periodically and develop plans for enhancing the functioning to higher levels. The residents shall be given responsibilities and work in the agency depending on their functional ability.

32. As most of the centers have no processes of rehabilitation assessment and rehabilitation planning, there should be a mechanism to ensure assessment of the client at the time of admission and a plan for rehabilitation to be set up. There could be a mechanism for reviewing the progress every month.
33. Volunteer consultancy services of mental health professionals may be utilized for enhancing the functioning of the center for effective patient care.

34. The centers shall continue and scale up the vocational activities closer to the natural settings of the residents

35. The centers shall consider developing common formats for documentation, with provisions for comprehensive data collection at admission including level of functioning and quality of life and ongoing assessment throughout the period of stay in the center. The personnel shall be trained in the documentation process.

36. The KFCMD shall develop a web based database of all residents for effective rehabilitation and community reintegration. It can include photographs, personal identification details and treatment history.

37. The clients shall be moved to alternative systems of care or community when they are fit for community living.

38. Discharge planning procedures to be adopted to sustain the benefits made and avoids relapses. Family psycho education shall be utilised for preparing families to take the patients back to home. The environments need to be prepared before discharge.

39. Community sensitisation programmes may be organised for community awareness on mental illness with the broad aims of
facilitating community reintegration of the recovered residents and enhancing support for the care facilities.

40. The centers shall devise mechanisms for follow up of discharged residents at the home settings to ensure medication compliance, sustaining the gains and preventing relapse. This could be done through developing volunteers in the community and through networking with community based organisations, student volunteers etc.

41. The centers should explore the possibilities of maintaining the centers or extension residential centers managed by residents themselves with minimal support from the center and other mental health professionals.

42. The centers should consider providing more stimulating and active recreational services to the residents.

43. Cleanliness of the centers needs improvement. The centers shall have a clear schedule for cleaning and should effectively utilize the residents. Each resident needs to be empowered to maintain the premises clean and tidy.

44. The residents shall be involved in the planning of center functioning and day to day functioning of the center. The centers shall adopt a therapeutic community approach for the functioning.

45. The centers shall devise plans for organised fund raising from different sources including the local community. The centers
also could consider charging fee for the services from the residents who are admitted by families.

46. The admission and discharge procedures shall be made in accordance with existing rules

47. The centers shall effectively make use of field practicum of social work, nursing students for strengthening the working of the centers.

8.16. Implications for Future Research

Since this being the first attempt in evaluating the process involved in the care and rehabilitation of homeless mentally ill, more scientific research is essential for documenting the rehabilitation process. Some of the recommendations are:

48. More research could be conducted to evaluate the outcomes in comparison with many groups viz.

- Long term care residents in Government Psychiatric Hospitals
- Residents in home based care
- Residents in paid rehabilitation centers
- Community based rehabilitation programmes for mentally ill
- Other types of rehabilitation facilities
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- Traditional and Natural Vocational Rehabilitation activities

49. The experimental design could be strengthened by adding control groups of homeless mentally ill persons in the streets (data on psychopathology may be difficult to be obtained)

50. The study also could consider pre and post assessment quality of life and functioning of residents by making the data gathering at the time of admission systematic and focused.

51. Qualitative methods could be adopted for the programme evaluation and documenting best practices.

52. The research could be further expanded to a follow up study residents who have been discharged to community with a longitudinal study design.

53. The research process could be performed in similar organisations in the whole country.

8.17. Recommendations for Professional Social Work

The following recommendations are formulated based on the findings of the study, highlighted the needs and gaps identified in the programme delivery. Social workers could support strengthening these centers with their professional involvement along with other mental health professionals.
54. The professional social work association may develop a resource pool of professionals willing to spare volunteer time for this low cost rehabilitation process.

55. The schools of social work could partner with one of these centers and provide ongoing technical support using the knowledge and skills of trained social work educators. The schools as well as professionals could provide their consultancy for

- These agencies could be used as a setting for field practicum placement of social work students.
- Developing a resource mobilisation plan and conducting resource mobilization drives for the center.
- Developing projects for expansion of the services.
- Perform networking and advocacy roles for strengthening job placement of recovered patients.
- Perform advocacy roles with policy makers for supporting and developing policies for the innovative rehabilitation model.
- Support for training of volunteers. The professional could perform training need assessment, prepare training modules, and conduct training programmes for the volunteers.
Findings and Suggestions

- They could consider performing intervention studies evaluating the effectiveness of training.

- Support in holding workshop and developing operational guidelines and manuals for the rehabilitation process to be adopted in these centers.

- Devising methodologies for community sensitization programmes,

- Developing Information Education Communication materials and

- Act as resource persons for community sensitisation programmes

56. Considering the possibility of field practicum and practice in these centers various methods of social work shall be effectively practiced in the centers.

a. Case work: for the whole process of rehabilitation of the resident starting from assessment, planning, goal setting, skill training, vocational training etc. to community reintegration and follow up.

b. Group Work could be used effectively for skill training, recreation of the residents.

c. Community organisation: The centers shall adopt community organisation techniques for enhancing the community support for the programme, public education
and effective community integration of recovered residents.

d. Social action could focus on rights of the homeless mentally ill and influence policy changes and necessary legislations.

e. Social Work research – more descriptive, experimental studies could be performed in these centers. The studies can create evidence base for these centers.

f. Social Work Administration – shall be utilized for efficient administration of these organisations.

Section 4: Conclusion

This comprehensive study described the facilities for rehabilitation of homeless mentally ill, rehabilitation processes adopted, quality of patient care services, personal profiles of chief functionaries, care providers and residents and rehabilitation outcomes. This has emerged as the first literature on these types of innovative, low cost rehabilitation facilities for homeless mentally ill in the state of Kerala. This is a viable, feasible and sustainable model of rehabilitation for resource poor countries. The centers cater to large number of homeless mentally ill in Kerala. The centers function with great support of public and have optimally used resources available within the centers. The outcome measures assessed in the study, quality of life, level of functioning and patient satisfaction showed similar results to many global studies done in professionally managed
Findings and Suggestions

rehabilitation centers. However, the research have identified several gaps in the implementation of the programme, which could be addressed with serious steps taken from policy level to the day to day functioning of the centers. The staffs are untrained, organised rehabilitation processes are absent, quality of documentation is scarce, admission and discharge procedures are not compliant with the existing legislations. Considering the commendable services offered by these centers, sensible and practical policies, with clearly planned protocols of service delivery could strengthen the services and could be proven as one of the innovative, low cost rehabilitation facility for homeless mentally ill: Kerala Model of Rehabilitation of Homeless Mentally ill.